Washington State Health Care Authority

Remicade (Infiximab injection) J1745 Request

Please Fax Response to: 1-866-668-1214
Medical Request Coordinator

Please Print. Please provide the information below. PRINT your answers, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

Without this information, the request may be denied in 30 days.

DATE OF REQUEST	CLIENT NAME		PROVIDERONE CLIENT ID
PRESCRIBER'S NAME			BILLING PROVIDER NPI NUMBER
TELEPHONE NUMBER	FAX NUMBER	DRUG/STRENGTH/DOSE (Procedure/HCPC Code: J1745)	

Is considered medically necessary under the following conditions:

1. Remicade is being used to treat ulcerative colitis (include confirmation date); and
   a. Remicade is prescribed by a gastroenterologist; and
   b. Client has tried and failed conventional therapy (include dates and doses of trial(s); and
   c. Client is 18 years of age or older; and
   d. Dose does not exceed a maximum for 5mg/kg given every 8 weeks after the induction regimen and 5mg/kg given at week 2 and week 6 of therapy.

2. Remicade is being used to treat ankylosing spondylitis, psoriatic arthritis, plaque psoriasis, or rheumatoid arthritis; and Remicade is prescribed by a dermatologist; and
   a. Client has tried and failed course of Enbrel or Humira (include dates and doses of trial(s)); and
   b. Client is 18 years of age or older; and
   c. For ankylosing spondylitis: Dose does not exceed a maximum dose of 5mg/kg given every 8 weeks after the induction regimen of 5mg/kg given at week 2 and week 6 of therapy; or
   d. For psoriatic arthritis and plaque psoriasis: Dose does not exceed a maximum dose of 5mg/kg given every 8 weeks after the induction regimen of 5mg/kg given at weeks 2 and weeks 6 of therapy; or
   e. For rheumatoid arthritis: Dose does not exceed a maximum dose of 10mg/kg given every 4 weeks.

3. Remicade is being used to treat Crohn's disease; and
   a. Client has tried and failed course of Humira (include dates and doses of trial(s)); and
   b. Client is 6 years of age or older; and
   c. Dose does not exceed a maximum dose of 10mg/kg given every 8 weeks.

1. What is the confirmation date for one of the above diagnosis?

   _____ _____
   (DIAGNOSIS) (DATE)

   Please attach supporting objective clinical documentation.

2. Client must have tried and failed other drugs for severe plaque psoriasis. What alternative medication(s) have been tried? What were the outcomes? How long was the trial?

3. If no other medication has been tried please explain why not.

4. If the requested dose is above maximum doses in 1. d; 2. c, d, e; or 3. c (as applicable), please provide justification and/or peer-reviewed medical literature providing evidence of safety and efficacy for dosing greater than what is FDA approved.

5. Age of client: _____

   Additional information:

PRESCRIBER SIGNATURE	PRESCRIBER SPECIALTY	DATE

A copy of the prescription must be attached to this request.

Fax to: **1-866-668-1214**
Or mail to: Medical Request Coordinator
PO Box 45535
Olympia, WA 98504-5535

A typed and completed *General Authorization for Information* form (13-835) must be attached to your request.